The contribution of Home Care to the construction of health care networks from the perspective of health professionals and elderly users

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Abstract

Objective: Analyze Home Care (AD) contribution to the consolidation of Health Care Networks(RAS) from the viewpoint of professionals and elderly users. *Method*: Qualitative research, through a semi-structured questionnaire, was carried out.Six professionals were included, by draw, each of them from an occupational category of Home Care Service in Sao Caetano do Sul, São Paulo, Brazil, and also 34 users aged over 60 years-old, conscious and oriented, engaged for, at least one year to AD, carrying HAS and DM simultaneously. *Results*: Subjects' profile - six professionals, five of them with higher education and one with technical education; average age 39, working in Home Care for approximately two years. Users were predominantly women, aged from 60 to 69 years-old, mostly married and with primary education. Data were categorized: Integrality of Health Care; Home Care and access to other health services; Training and skills in Home Care. It was observed integration among professionals of the sector, valuing biopsychosocial context and guiding actions in the care process. However, deficiency in intersectional articulation was detected. *Conclusion*: Co-responsibility, training and professional skills were related to an efficient service. Results showed that a humanized approach, bonding, and the effective participation of caregivers and families favor the execution of a therapeutic project and rehabilitation. Home care interconnects RAS points: de-hospitalization guides health care flow. Nevertheless, RAS members' awareness of Home Care practice, professional training and empowerment of caregivers should be improved.

Keywords: Home Care Services.Integrality in Health. Aging.Longevity. Health Care.

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INTRODUCTION

The Brazilian Unified Health System (*Sistema Único de Saúde* or SUS), created under the 1988 Constitution, establishes Health as a right for everyone and the duty of the State, based on the following doctrine: Universality, Integrality and Equity[1].

In 30 years of the conception and practices of the SUS, there have been challenges and paradoxes between doctrinal idealism and the heterogeneity of practical scenarios, sensitive to epidemiological transitions and to socioeconomic policy. Unprecedented demands require creative approaches and technologies. In this context, the practice of Integrality – the integration of preventive and curative acts, on an individual and collective level, at all levels of healthcare and the valuation of the individual as well as the disease, considering a biopsychosocial approach[2] - is a goal pursued on a daily basis. This semantic plurality makes Integrality a device to organize working relationship, promoting environments of discussion for the review of health processes[3].

In Brazil, increased life expectancy at birth and a reduction in death and birth rates define the process of population aging. This transformation of the age profile has a qualitatively important impact on the morbidity and mortality scenario, revealing a predominance of chronic noncommunicable diseases (CNCD). These require prevention - at different levels - and control through the broad reach, low cost strategies adopted in Primary Health Care (PHC). Inefficiency of actions at this level of complexity leads to an increase in potentially avoidable expenditures.

Based on the epidemiological importance of CNCD in relation to the current health system, there is a fragmentation of care in the Health Care Network (HCN) – the dynamic arrangement of health apparatus, with different levels of technological intensity, which are interconnected, aimed at providing integral care to the user -impairing the effectiveness of primary and secondary prevention actions, culminating in avoidable hospitalizations and high mortality rates due to cardiovascular and cerebrovascular diseases. It is essential to manage care, idealizing interdisciplinary care focused on health promotion and protection, as a priority for rehabilitation[4-6].

In this manner, the Family Health Strategy (FHS) was established in PHC in 1994 to not only contemplate these services, but also to lead the reorganization of PHC, through territorial ascription to interdisciplinary action, active seeking out and the bonding of stable bonds, among other strategies. In the midst of the significant importance of strengthening care at home, Home Care (HC) was subsequently established as a tool to expand practical scenarios and meet user needs.

HC is a federal program that envisages the expansion and qualification of home care under the SUS. Composed of services that are complementary to or substitutes for the hospital and outpatient spheres, it aims at continuity of care and integration into the HCN[7]. It allows full knowledge of the user: their routine, culture and family, and promotes the implementation and articulation of rehabilitation, preventive, educational and health promotion actions[8,9].

Faced with the need to standardize and regulate HC, the Ministry of Health created the Better at Home Program[7] in 2011. In 2013, it increased financial support and technical support to healthcare managers, reformulating regulations and stimulating organized growth[10]. In 2016, it redefined its directives[11,12]. In São Caetano do Sul (São Paulo), this modality emerged in 2012. It includes patients from Home Care II – medium complexity care and Home Care III - high complexity care, with Home Care I patients, who are of low clinical complexity, treated in the FHS[7,13]. The HC morbidity profile is composed mainly of elderly people with CNCD (cardiovascular, cerebrovascular, neoplasia, neurodegenerative conditions), with varying degrees of dependence. Considering the increase in the numbers of cases of these diseases later in life, there is a clear need for specific, qualified care[14].

The transversal nature of HC - communication between segments of different health complexities, valuing co-responsibility independently of hierarchy, adapting real needs to care protocols[15]- ensures efficiency and restructuring of the work process in PHC, especially in hospitals. Consequently, it optimizes

hospitalizations, humanizes care and strengthens institutions, increasing the autonomy of users[16].

The present study sought the following information: how do health professionals from HC -São Caetano do Sul assess the organization of the service in their respective HCN? What strategies are used by the HC professionals to facilitate dialogue between the components of the HCN?

The understanding of HC users regarding the dynamics of care is relevant. A lack of knowledge about levels of complexity and access can generate risks in use and flow. We asked this population: how important is the division of responsibilities between users, family and HC professionals, as well as ease of access and integration with the team, to achieving successful care?

It is hoped that this study will allow the preliminary identification of effective actions, the real needs of users and possibilities for intersectoral dialogue, contributing to the alignment of public policies. The objective is to analyze the contribution of HC to the construction of HCNs, from the perspective of professionals and elderly users.

METHOD

A qualitative study[17] was carried out from November 2016 to January 2017 in São Caetano do Sul, in the state of São Paulo. The subjects of this study were selected from different populations, composing two independent samples: health professionals and users. The data were collected through an interview, of approximately sixty minutes in duration, guided by a semi-structured script[18] containing closed and open questions, with a specific instrument for each sample, proposing a dialogue between researcher and subjects.

The interviews, which were previously scheduled, were carried out by the researcher themselves who, with the express authorization of subjects and managers, then approached the subjects individually and, for the sample of users, authorized relatives and/or caregivers to remain with the patient in cases of physical dependence. The dialogues were recorded, transcribed in their entirety and carried out only once, preserving the spontaneity of the subjects. After transcription the subjects had no further access to the questionnaire. As a basis for the interviews, a questionnaire similar to that of a study developed in Minas Gerais in 2013 was used.[18]

In both questionnaires, data were compiled to characterize the profile of the subjects. The open questions for the health professionals addressed knowledge of organization and articulation within the network; access; communication facilitation strategies among HC actors; professional training. For the users, the aim was to establish notions of access; relationship of responsibility in care between the service, the family and the network user; interdisciplinary action; functioning of HC. In view of the variables presented, categories of discourse analysis were constructed to interpret the results obtained.

The sample universe was the patients and users of the HC network of São Caetano do Sul[19], a choice justified by the high prevalence of elderly users of the public health system, the multiprofessional nature of the network and the previous professional insertion of the researcher in the service and their greater familiarity with the same. This proximity posed a challenge and efforts to preserve impartiality were redoubled. Users were interviewed in their homes; health professionals, at the administrative headquarters of the service.

Of the 16 health professionals of HC-São Caetano do Sul, six subjects were selected, with each category represented at the prerogative of the researcher, in order to value the multiprofessional nature of the service - unitarily in the sample there were: a nurse, a doctor, a nursing assistant, a physiotherapist, a speech therapist and a social worker. For Social Assistance and Speech Therapy, which had a single representative in the sector, inclusion in the sample was automatic; for the other functions, lots were drawn.

Users of both genders were also screened according to the following criteria: age over 60 years, enrollment and minimum follow-up of one year by the HCII or HCIII team; conscious and oriented; patients with systemic arterial hypertension (SAH) and Diabetes *mellitus* (DM), due to the already mentioned epidemiological relevance. The cognitive exclusion criterion was insufficient cognitive capacity

to comprehend the questions. A total of 34 users (28.33%) were selected through analysis of their medical records, out of a total of 120 registered in the HC network. There are approximately 1,000 domiciled SAH and DM (simultaneous) sufferers in the SUS.

In terms of longevity, São Caetano do Sul surpasses the Brazilian average: the life expectancy of 13% of Brazilian elderly persons is 75; for 19.10% of residents of São Caetano do Sul, it is 78[19,20].

The discourses of the subjects were identified with P for professionals and U for users, followed by a specific numeral of each interview.

To comply with ethical principles (Resolution 466/2012 and 510/2016), the present study was assessed by the Director of Basic Health and the Municipal Health Secretary of São Caetano do Sul and approved under opinion number: 1.879.905 by the Ethics Research Committee of the Municipal Health Foundation of São Caetano do Sul. The subjects signed a Free and Informed Consent Form.

RESULTS AND DISCUSSION

All six of the HC professionals were female, and the mean age was 39 years (34 to 50 years). Time spent working in HC (years) and time elapsed since graduation (years) were also evaluated (Figure 1).

Regarding level of education, five professionals (83.33%) had a complete higher education and one participant had a technical qualification. Among the professionals with a higher education interviewed, two had specialization qualifications in HC and/or the FHS: the nurse and the doctor.

There is a high turnover of professionals, whether due to readjustment of hours, non-specific training or administrative issues. Such a panorama necessitates the permanent provision of specialization and improvement courses in HC[18,21,22].

In the sample of 34 users, the female gender predominated. Figure 2 shows the age group of the users.

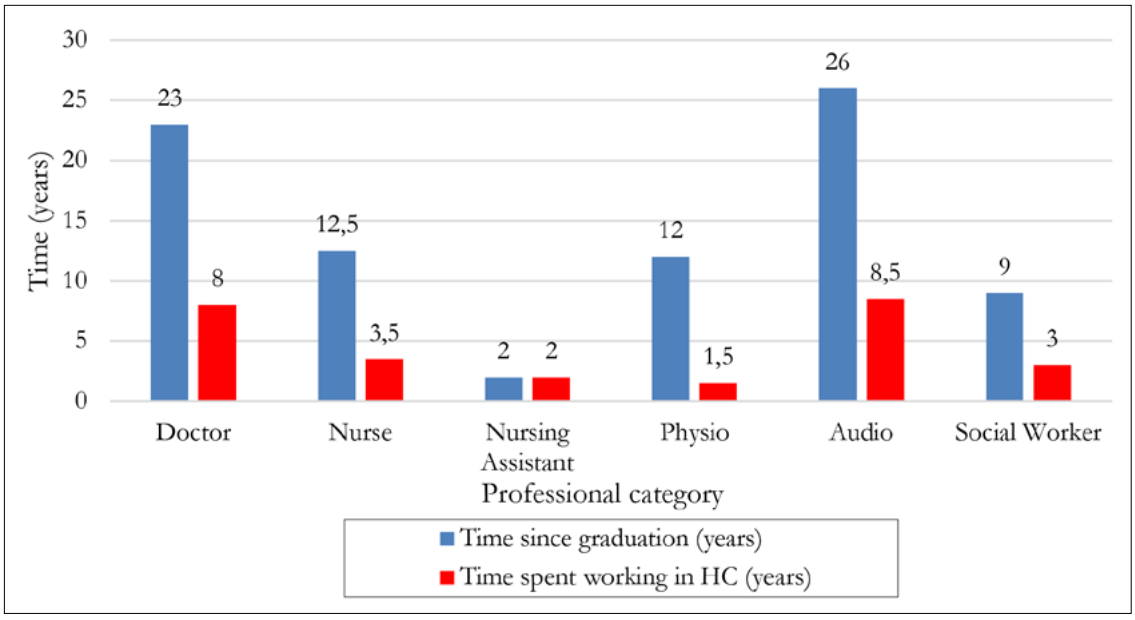

Figure 1. Time spent working (years) in HC service and time since graduating (years) of HC professionals. São Caetano do Sul, São Paulo, Brazil, 2017.

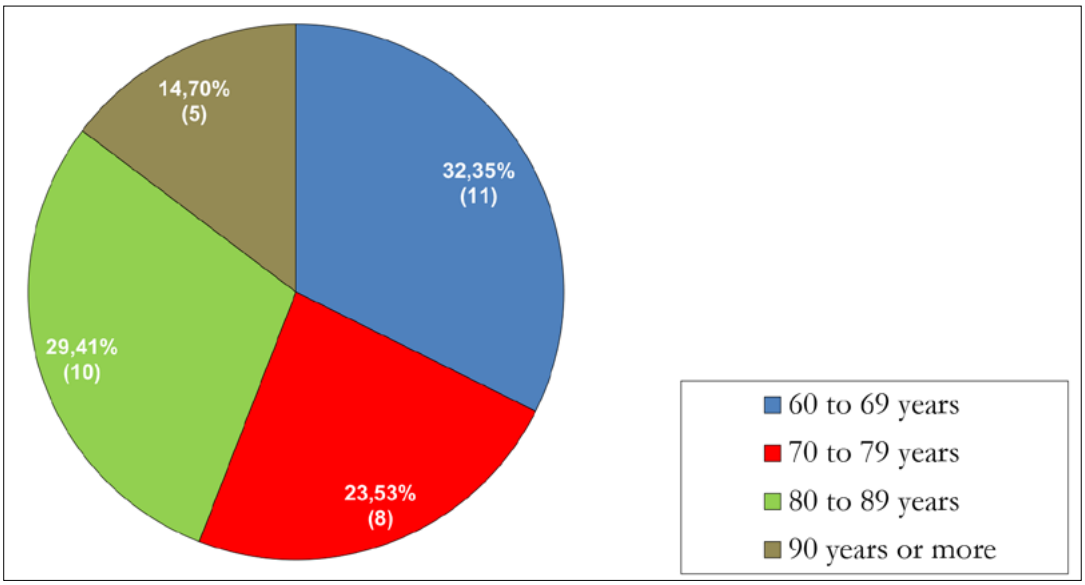

Figure 2. Age distribution of sample of HC users (N=34). São Caetano do Sul, São Paulo, Brazil, 2017.

Regarding marital status, four categories were cited: married (44.12%) (n=15) of the total; widowed (41.18%) (n=14); single (11.76%) (n=4); and separated (2.94%) (n=1). Educational level was distributed as follows: 82% (n=3) were illiterate, 61.77% (n=21) had completed primary education, 23.53% (n=8) had completed high school and 5.88% (n=2) had a higher level education.

Of the users, 85.29% (n=29) received medium complexity care and 14.71% (n=5) high complexity, according to the Katz scale[23,24], which defines categories of dependence according to performance in the basic activities of daily living (bathing, clothing, personal hygiene, transference, continence and feeding). Figure 3 illustrates this distribution.

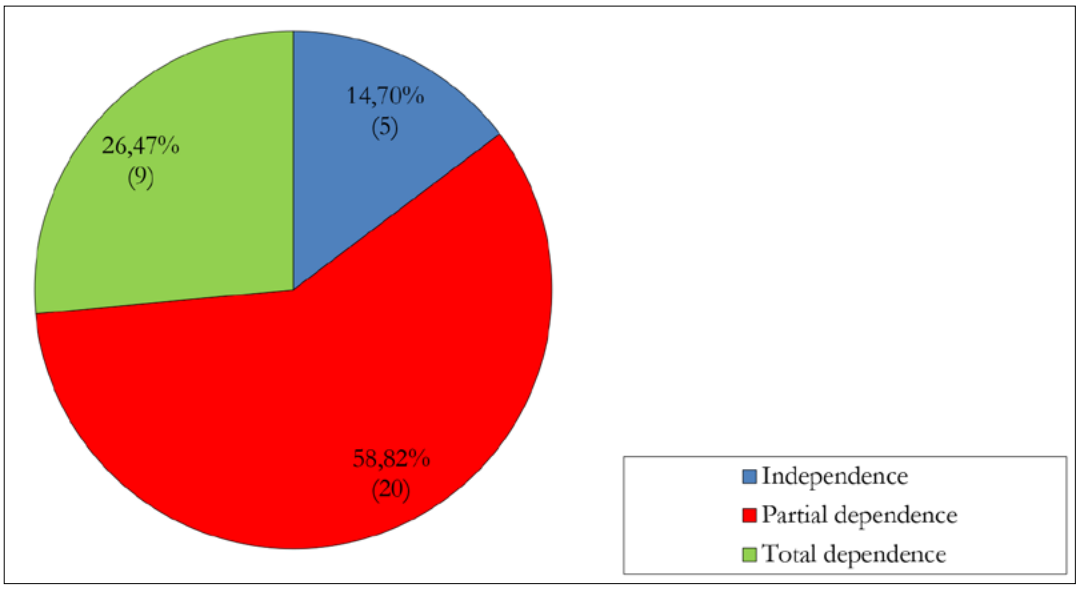

Figure 3. Degree of dependence of HC users (N=34) according to Katz[23]. São Caetano do Sul, São Paulo, Brazil, 2017.

Most of the elderly persons had good ties with health professionals, their family and caregivers. They considered the public sector responsible for difficulties in attending to their needs (access, Integrality, Equity) and in assistance with the management of their physical and cognitive disabilities, sometimes contributing little to satisfactory performance in their activities of daily living[25,26].

As identified by Veras[27], increased longevity leads to greater use of public and private health services, generating more costs and threatening the sustainability of the system. One way of preventing collapse is to invest in policies for disease prevention, stabilization of chronic diseases and maintenance of the functional capacity of the sick.

Regarding socioeconomic profile, there is a heterogeneity in the conditions and location of housing and resources available to families. Extremes were identified, from the 24-hour permanence of caregivers to users who were alone and did not have such support. The caregiver emerges as a fundamental actor for users with partial or total dependence in the performance of daily life activities (Figure 4).

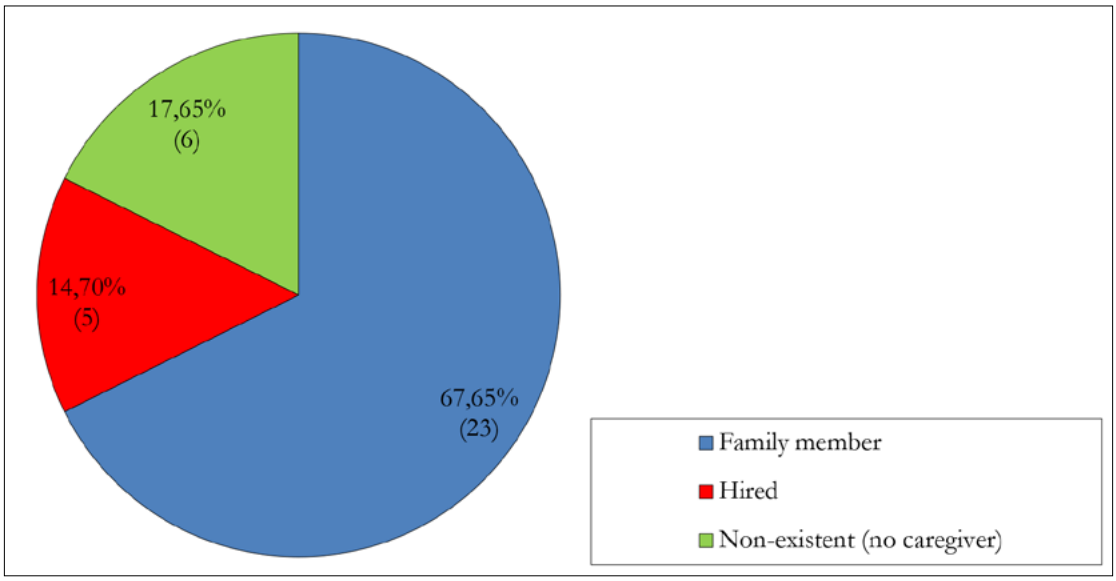

Figure 4. Distribution of sample of HC patients from São Caetano do Sul, (N=34), based on existence of caregiver and nature of caregiver-patient relationship. São Caetano do Sul, São Paulo, Brazil, 2017.

In order to systematize the information, the analysis of the data obtained consisted of three categories of analysis: Integrality of health care; HC and access to other health services; Interdisciplinary team, training and skills in HC.

Integrality of health care

Professionals and users cite important characteristics for the effective construction of the health care network, such as continuous and comprehensive provision of care:

"When I was discharged, I was promptly attended to at my home by a team with several professionals, who provided all the necessary care ... However, on another visit I noticed that one professional did not give the same instructions as the other and I got confused in following them [...]"(U8).

"[...] We try to plan the first home visit in a team so that we can establish a single line of care [...]"(P6).

"[...] The HC network can link up with other services, but many professionals are constantly changing, and teams that aren't big enough feel the effects [...]" (P3).

The incongruence of the team is observed in decision-making, making patient adherence and the measuring of results difficult. Adding to this scenario, the lack of counter-referral makes the network disconnected. Perhaps this is why HC was mentioned as a specific form of care to be used at a certain time, and is not seen as integral care[14,28,29].

> "[...] When I refer my patient to the specialist, I am careful to send a letter explaining the case. However, when the case returns, I receive no guidance or explanation as to the proposed conduct [...]"(P2).

The existence of an integrated computerized system for recording information could facilitate communication between the various points of the network.

> "[...] when I need treatment in another of the city's services, I have to tell my whole story again. There is no conversation among professionals, not even with an information system [...]"(U14).

The subjects demonstrated an understanding of the organization of health services linked to the provision of care, generally related to different degrees of complexity established by the organization of SUS: PHC, represented by the Basic Health Units (UBS) or Family Health teams; Secondary Care, represented by specialist centers; Tertiary Care, represented by the hospital network. In São Caetano do Sul, the hospital network is considered to be secondary level of complexity.

> "[...] There are health centers, which we almost always use ... There is the municipal hospital, emergency units and there are also the specialist centers [...]" (U12).

When HCII and HCIII were specifically addressed, the subjects understood these to be care modalities within the HCN. However, they referred to the absence of flows and protocols to guide and optimize the services of the network.

> "[...] I'd emphasize the need to create protocols and improve the registration of information in medical records to improve the work process and avoid the loss of the patient's history [...]" (P4).

> "[...] I see a difference in the care provided by the professionals... I'm treated one way in HC, and other way at the BHU, and another way at the hospital [...]" (U13).

While there is a longitudinal approach, that is, ongoing care based on the protocols of the teams, interdisciplinarity - desirable for the improvement of care - still requires adjustment, with the autonomous actions of each specialty prevailing, reflecting only the multidisciplinary nature of care.

Dehospitalization triggers the flow of care offered by HCNs, with HC of strategic importance. Interdisciplinary dialogue, intra-hospital visits, and the planning and training of the care to be offered at home are essential measures of articulation within the system, adding an integrative vision to the health-disease process. In the interviews with the professionals, there were references to problems to be overcome, such as: the difficulties of families in providing care, the acquisition of equipment, the adapting of homes, the difficulty in finding home care professionals, the fragmentation of care and the lack of health education provided at discharge.

> "[...] The social worker and the nurse paid a visit to the hospital before discharge. There they informed us about how it would work at home and what the HCN follow-up would be like [...]" (U7).

> "[...] I started my examination of the patient's history in the hospital, when we are called by them to start the de-hospitalization process [...]" (P6).

It was identified that HC has a mediating role between patient, caregiver, professionals and the health system, especially in the process of dehospitalization, offering positive results in the hospital-home transition, an impression corroborated by the users. The exchange of knowledge and experiences between these actors minimizes the fragmentation of care and contemplates several dimensions of care. Nevertheless, the experience described by the social care and nursing professionals allows them to understand the importance of home care to integrality and continued care.

An important initiative cited by interviewees was the use of matrixing moments[30] with the Family Health teams to discuss the cases to be referred to HCII and HCIII.

> "[...] I take part in the matrix planning meetings of the family health teams every week. It is an enriching moment, since it allows dialogue about referral and counter-referral between the FHS and HC, as well as the chance to discuss the profile of the patients and referrals [...]" (P4).

In this way, the contribution of the HC to the networks can be inferred, with strengthening necessary through interdisciplinary meetings for the implantation of flows and protocols and the improvement of the provision of services.

Home care and access to other health services

Analyzing the behavior of the actors in the care process helps to improve the system, as it allows discussion of the ways to overcome gaps in the implementation of Home Care in the HCNs, in the pursuit of Integrality[2,3,31].

> "[...] when we are sent to the service in another part of the network, we wait the same time as the other patients, but we are bedridden and we should have priority ... We wait when the appointment is scheduled and we wait to schedule it ... We get a different level of service when the health professionals intervene" (U8).

> "[...] Often the process does not work and we use personal contact to solve the problems of the users. This communication needs to be improved. [...]" (P4).

> "[...] The Interdisciplinary Team needs to prioritize and establish a schedule of visits and procedures [...]" (U9).

> "[...] the HC works only during the week and during business hours, this means that we use the emergency room frequently at weekends and at night, even just to use medications [...]" (U5).

> "[...] there is a need for dialogue among HC professionals so that we can share and plan the treatment of the patient together [...]" (P5).

The analysis of the interviews reveals difficulties regarding access, explained in intercurrences outside the hours of operation of the service and the absence of priority treatment, in addition to problems originating in the alignment of conduct among the team.

Given these limitations, it is emphasized that the care given to the user is not always focused on a holistic approach and sharing responsibilities with the family, which would optimize home-based alternatives.

The users use different services in several points of the HCN, as they have unstable clinical conditions, which generates insecurity among their family and caregivers, despite the guidelines received. It is necessary to expand and align the services offered by the HCN[32].

It is vital to establish a relationship between the services, as the clinical picture tends to be heterogeneous, overlapping and endowed with multiple intervening factors. HC is capable of transmitting security to family and patients since, as besides the technical specificity of the care it provides, it promotes access to other apparatus (referral) according to the qualification of need (Principle of Equity).

Interdisciplinary team, training and skills in home care

The professional training refers to the idea of adding to and updating knowledge or skills, essential strategies for health care.

> "[...] There is a need to standardize HC care so that all the professionals use the same language and approach [...]" (P6).

High turnover and the inadequate composition of the interdisciplinary team suggests weaknesses in the work process, culminating with the impression of unqualified care.

> "[...] I see a need to provide a greater number of professionals to offer full care, as well as offering a complete interdisciplinary team to carry out the service [...]" (P2).

HC practices do not replace the process of technical training. There are professionals who have worked for a long time in the service, however, without specific HC or FHS qualifications, resulting in a perspective that is sometimes merely centered on the individual and their treatment, excluding health promotion strategies. Interdisciplinary meetings can result in considerable gains in the structuring of HC.

> "[...] the lack of team meetings means the improvement of actions and procedures in HC is impossible [...]" (P4).

The interdisciplinary team presents difficulties in the construction of dialogue with the services provided, in spite of the existence of clinical criteria that delimit fields of action and referral requirements. A bureaucratic, non-resolutive approach prevails, imposing barriers for users. Strategies that optimize supply in relation to demand should be adopted[33].

Linking and reception are employed in the search for effective customer service from the first intervention until discharge. Integrating Home Care into the HCN is a great challenge, notably for Family Health teams[33].

> "There is a great dependence of users on the care offered to the patient or family member ... Even after guidance from the team regarding basic care ... the family is reluctant to carry it out [...]" (P6).

> "[...] I feel secure when the HC team takes over care [...]" (U17).

The emphasis on care dimensions involving all actors, such as the family approach, training caregivers and providing guidance on the services offered in the various points of the HCN, encourages the promotion of qualitative changes and reinforces commitment among health professionals, individuals, families and the community.

Considering these strategies, the professionals cite tools that they consider essential to adapt Home Care to the HCN: implantation of electronic records, the definition of protocols, the emphasizing of the adequacy of instruments that facilitate the practice of care; the withholding of the hospital bed for the continuity of treatment.

The importance of constant training for professionals and caregivers was also cited. The matrix support strategy is a rich space for sharing knowledge, interdisciplinarity and the construction of therapeutic planning directed at individuality. It is up to the professionals to guarantee the integrality of the practices adopted[34].

Thus, Home Care forms part of the HCN as a device for the restructuring of service, a facilitator of dialogue through the actions of dehospitalization, matrix planning and the domiciliary visits of the interdisciplinary team, contributing to a reduction in costs, by reducing the time and number of hospitalizations and minimizing the demand for emergency care services[7,18,35].

As it is a modality of care within Brazil, there are difficulties regarding the consolidation of Home Care in parallel with the HCN: a lack of clarity on the part of users regarding the operation of the service, the reduced supply of equipment and infrastructure and insufficient investment in specific training for professionals. The expansion of the HCN brings the possibility of strengthening HC, making it the communication hub between services.

Although the statements of the interviewees allow some favorable inferences regarding the role of HC in the categories considered, as well as the construction of hypotheses that will be subsequently tested, it would be premature to be satisfied with the assertiveness of the answers to the questions that guide the present study, due to the plurality and subjectivity of the content obtained. The design, by itself, presupposes a systematized complement so that the information and evidence collected here supports the strengthening of HCNs. Over time, integrating categories through responses is a valuable exercise in understanding the interdependence of processes and selecting priorities.

CONCLUSION

In the midst of the existence of correlated care modalities that contemplate different levels of complexity in the Brazilian health system, Home Care occupies a well-defined niche:

interdisciplinary therapeutic planning, with practices that favor alignment among all the actors involved (professional, family, caregiver, patient) carried out at home, with constant management and reassessment of the actions in the Health Care Networks. This construction process, when developed in an integrated and phased manner, favors quick decision making and offers a satisfactory safety margin, prerequisites for effectiveness with patients of medium and high complexity.

Communication and articulation between points of the Health Care Network are foundations for a transversal approach. Examples include: deployment of recovery beds, systematization of the work process to encourage counter-referrals; interface with Basic Care to improvement patient care, avoiding unnecessary hospitalizations; flexibility in hours of Home Care functioning.

Hospital discharge implies optimizing services and avoiding rehospitalization. Home Care seems to respond to the interlocution and execution of the process, with respect to the readjustment and even the transfer of care to the home context in order to guarantee the continuity of the service which began in the hospital network.

The importance of a collective approach is clear, from tripartite development to the formulation, revision and execution of protocols that favor interprofessional communication in the various sectors of care, establishing information flow and embracing the concept of Integrality, reducing iatrogenesis. Qualified listening with an interdisciplinary team duly prepared to approach and address needs inherent to senescence and the peculiarities of the home, will allow the construction of a feasible and shared therapeutic plan.

Further studies are also needed to detect and explore the potentialities and weaknesses of Home Care so that there is sufficient support for robust conclusions and the possibility of expanding the strategies offered to different biopsychosocial contexts and Health Care Network structures.

REFERENCES

1. Brasil. Constituição (1988). Constituição da República Federativa do Brasil [Internet]. Brasília, DF: Senado Federal; 1988 [acesso em 13 nov. 2015].Disponível em: http://www.planalto.gov.br/ccivil_03/Constituicao/Constituicao.htm
2. Mattos A, Pinheiro R. Os sentidos da integralidade: algumas reflexões acerca de valores que merecem ser defendidos. In: Mattos RA. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: UERJ; 2001. p. 39-64.
3. Kalichman AO, Ayres JRCM. Integralidade e tecnologias de atenção à saúde: uma narrativa sobre contribuições conceituais à construção do princípio da integralidade no SUS. Cad Saúde Pública.2016;32(8):1-13.
4. Brasil.Resoluçãoda Diretoria Colegiada nº 11, de 26 de janeiro de 2006. Dispõe sobre o regulamento técnico de funcionamento de serviços que prestam Atenção Domiciliar. Diário Oficial [da]União.30 jan. 2006; Seção 1.
5. Miranda GMD, Mendes ACGM, Silva ALA. O envelhecimento populacional brasileiro: desafios e consequências atuais e futuras. RevBrasGeriatrGerontol. 2016;19(3):507-19.
6. Silva KL, Sena RR, Seixas CT, Feuerwerker LCM, Merhy EE.Atenção Domiciliar como mudança do modelo tecnoassistencial. RevSaúde Pública.2010;44:166-76.
7. Brasil. Portaria nº 2527, de 27 de outubro de 2011. Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde. Diário Oficial [da] União.28 out. 2011; Seção 1:44.
8. Oliveira SG, Kruse MHL. Gênese da atenção domiciliária no Brasil no início do século XX. RevGauchEnferm.2016;37(2):1-9.
9. Wachs LS, Nunes BP, Soares MU, FacchiniLA, ThuméE. Prevalência da assistência domiciliar prestada à população idosa brasileira e fatores associados. Cad Saúde Pública.2016;32(3)1-9.
10. Brasil. Portaria nº 963, de 27 de maio de 2013. Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde. Diário Oficial [da] União.28 maio 2013; Seção 1:30.
11. Brasil. Portaria nº 825, de 25 de abril de 2016. Redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde. Diário Oficial [da] União. 26 abr. 2016; Seção 1:33.

12. Guerra CD, Torres JMC, Gándara AR, Alonso AM, Borrego MAR. Visita agendada do profissional de enfermagem a idosos em seu domicílio: prevenção ou tratamento. RevLatinoamEnferm.2015;23(3):535-42.

13. Brasil. Ministério da Saúde, Departamento de Informática do SUS. DATASUS. [Internet]. Brasília, DF: MS; 2015. Serviço de Atenção domiciliar: melhor em casa;[acesso em22 jun. 2015]; [2 telas]. Disponível em: http://www2.datasus.gov.br/DATASUS.

14. Guedes MBOG, Lima KC, Caldas CP, Veras RP. Apoio social e o cuidado integral à saúde do idoso. Physis. 2017;27(4):1185-204.

15. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde. Política Nacional de Humanização (PNH). Brasília, DF: MS; 2013.

16. Viana ALA, Bousquat A, Melo GA, Negri Filho A, Medina MG. Regionalização e Redes de Saúde.Ciênc Saúde Colet.2018;23(6):1791-98.

17. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo: Hucitec; 2014.

18. Andrade AM. Estruturação da rede de atenção à saúde na perspectiva de profissionais, usuários e cuidadores da AtençãoDomiciliar [dissertação]. [Belo Horizonte]: Universidade Federal de Minas Gerais; 2013.

19. Instituto Brasileiro de Geografia e Estatística [Internet]. Censo 2010. Rio de Janeiro: IBGE; 2013 [acesso em 10dez. 2017]. Disponível em: https://www.ibge.gov.br/index.php

20. Simões CCS. Relações entre as alterações históricas na dinâmica demográfica brasileira e os impactos decorrentes do processo de envelhecimento da população. Rio de Janeiro: IBGE; 2016.

21. Joaquim FL, Camacho ACLF, Sabóia VM, Santos RC, Santos LSF, Nogueira GA. Impacto da visita domiciliar na capacidade funcional de pacientes com úlceras venosas RevBrasEnferm.2016;69(3):468-77.

22. Valle ARMC, Andrade D, Sousa AFL, Carvalho PRM. Prevenção e controle das infecções no domicílio: desafios e implicações para enfermagem. Acta Paul Enferm 2016;29(2):239-44.

23. Katz S, Ford AB, Moskowitz RW, Jackson BA, Jackson BA, Jaffe MW. Escala de Atividades Básicas de Vida Diária - Escala de Katz.JAMA. 1963:914-6.

24. Veras RP, Oliveira M. Envelhecer no Brasil: a construção de um modelo de cuidado. Ciênc Saúde Colet. 2018;23(6):1929-36.

25. Medeiros KKAS, Pinto Junior EP, Bousquat A, Medina MG. O desafio da integralidade no cuidado ao idoso no âmbito da Atenção Primária à Saúde. Saúde Debate. 2017;41(Esp. 3):288-95.

26. Carnut L. Cuidado, integralidade e atenção primária: articulação essencial para refletir sobre o setor saúde no Brasil. Saúde Debate.2017;41(115):1177-86.

27. Veras RP. Prevenção de doenças em idosos: os equívocos dos atuais modelos.Cad Saúde Pública.2012;28(10):1834-40.

28. Pozzoli SML, Cecílio LCO. Sobre o cuidar e o ser cuidado na Atenção Domiciliar. Saúde Debate.2017;41(115):1116-29.

29. Giovanella L, Santos AM. Gestão do cuidado integral: estudo de caso em região de saúde da Bahia, Brasil. Cad Saúde Pública.2016;32(3):1-15.

30. Campos GWS, Domiti AC. Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde. Cad Saúde Pública.2007;23(2):399-407.

31. Silva CSO, Fonseca ADG, Souza LPS, Siqueira LG, Belasco AGS, Barbosa DA. Integralidade e Atenção Primária à Saúde: avaliação sob a ótica dos usuários. CiêncSaúde Colet.2014;19(11):4407-15.

32. Sarges NA, Santos MIPO, Chaves EC. Avaliação da segurança do idoso hospitalizado quanto o risco de quedas. RevBrasEnferm.2017;70(4):896-903.

33. Assis MMA, Jesus WLA. Acesso aos serviços de saúde: abordagens, conceitos, políticas e modelo de análise. CiêncSaúde Colet.2012;17(11):2865-75.

34. Lopes GVDO, Vilasbôas ALQ, Castellanos MEP. Atenção Domiciliar na Estratégia Saúde da Família do grau de implantação em Camaçari (BA). Saúde Debate.2017;41(N. Esp. 3):241-54.

35. Ferreira FPC, Bansi LO, Paschoal SMP. Serviços de atenção ao idoso e estratégias de cuidado domiciliares e institucionais. RevBrasGeriatrGerontol.2014;17(4):911-26.